Date

Contact Name
PPO Provider Name
Address
City, ST 00000

Dear XX:

Enclosed is your $50 Base Guaranteed Payment from the Coventry First Health Settlement. You may be eligible to file a claim for additional money. Please read the enclosed Claim Forms and Instructions for more information about filing a claim. The additional amount you receive will depend upon the total number of people who decide to participate, and the size of their claims.

You must file your claim(s) by mail using the enclosed prepaid envelope by Month 00, 2014 to get your payment(s).

If you have further questions:

- Visit www.CoventrySettlement.com;
- Call 1-800-000-0000
- Email Administrator@coventrysettlement.com

Sincerely,

Dennis J. Hubel
United States Magistrate Judge
U.S. District Court
District of Oregon

COVENTRY FIRST HEALTH SETTLEMENT

INSTRUCTIONS FOR CLAIM FORM FOR ADDITIONAL GUARANTEED PAYMENT

You have received Notice of the Settlement in *Chehalem Physical Therapy, Inc. v. Coventry Health Care, Inc.,* Case No. 3:09-CV-320-HU, along with a Base Guaranteed Payment. You may be eligible to receive an Additional Guaranteed Payment under this Settlement. More information about the lawsuit and claims process is in the Detailed Notice available at www.CoventrySettlement.com or by calling 1-800-000-0000.

If you believe you are eligible to receive an Additional Guaranteed Payment, you must mail the enclosed Claim Form along with all required documentation listed below to the Claims Administrator, postmarked on or before **Month 00, 2014.** Please read and follow these instructions carefully.

1. **INSTRUCTIONS.**

- ☐ Fill out the enclosed Claim Form completely and accurately. **If you cannot check all boxes in Section 2 of the Claim Form, you are not eligible to submit a claim as a Self-Identified Class Member.**
- ☐ Sign and date the Claim Form, declaring its accuracy under penalty of perjury.
- ☐ Make at least two copies of each of the documents listed below.
- ☐ Mail a copy of the completed and signed Claim Form, along with one copy of each document listed below by First Class mail postmarked by **Month 00, 2014**, to:

Coventry First Health Settlement
P.O. Box 0000
City, ST 00000

- ☐ Do not send any original documents to the Claims Administrator. The Claims Administrator will not return any documents to you.
- ☐ Keep a copy of all documents for your own records.

2. **DOCUMENTATION (TO BE ENCLOSED WITH THE CLAIM FORM).**

- ☐ The first page of your PPO provider agreement showing that it is a First Health provider agreement;
- ☐ The signature page and any other appropriate pages of your PPO provider agreement showing that it was executed by you and First Health and was in effect at some time between April 1, 1998, and June 30, 2007; and
- ☐ The Appendix A to your PPO provider agreement showing that it uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees.

3. CLAIMS ADMINISTRATION PROCESS.

All claims will be reviewed. The Claims Administrator will determine whether you are a Self-identified Class Member eligible for an Additional Guaranteed Payment based only on the Claim Form and documents you submit.

Using the first page of your provider agreement, the Claims Administrator will verify that:

- ☐ The contracting party is First Health and the agreement identifies you as the provider submitting the claim;
- ☐ Both you and First Health executed the provider agreement, and your agreement was in effect at some time between April 1, 1998, and June 30, 2007; and
- ☐ The Appendix A to your provider agreement uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees.

If your claim as a Self-identified Class Member is valid, your Additional Guaranteed Payment will be a proportional share of the money remaining in the $5 million Guaranteed Fund of $5,000,000 after all Base Guaranteed Payments are made. The amount you receive will be calculated by dividing the amount of the remaining Guaranteed Fund by the number of Self-Identified Class Members with valid claims (as determined by the Claims Administrator). You are not required to prove that you submitted bills with a billed charge for a service that was less than the state or federal fee schedule amount for that service to be eligible to receive an Additional Guaranteed Payment as a Self-identified Class Member.

4. IMPORTANT INFORMATION.

Claim Forms that do not meet the requirements described in these instructions will be rejected. In addition, the Claims Administrator may reject your Claim Form for any of the following reasons:

- ☐ Failure to provide adequate documentation of your claim;
- ☐ Failure to fully complete and/or sign the Claim Form;
- ☐ Any information on the Claim Form or supporting documentation is false or inaccurate;
- ☐ Your Claim Form duplicates another Claim Form; or
- ☐ You are not a member of the Settlement Class.

The Claims Administrator will notify you if your claim is invalid, challenged, or rejected. You must keep the Claims Administrator informed of your current mailing or email address. If you do not, you may not receive payment. If you have any questions about the claims process, please contact Class Counsel or the Claims Administrator. Please do not contact the Court or Coventry's counsel with questions about the claims process.

Payments will be made after final approval of the Settlement by the Court and after any appeals are resolved. This process may take time. Please be patient.

Must Be Postmarked No Later Than Date

Coventry First Health Settlement Administrator
P.O. Box 0000
City, ST 00000

COVENTRY FIRST HEALTH SETTLEMENT CLAIM FORM

ADDITIONAL GUARANTEED PAYMENT FOR SELF-IDENTIFIED CLASS MEMBERS

If you want to receive an Additional Guaranteed Payment under this Settlement, you must provide the information requested below with the required documentation. Please print clearly in blue or black ink.

More information is available at the official Settlement website, www.CoventrySettlement.com, or by calling 1-800-000-0000. This Claim Form must be mailed and postmarked on or before **Month 00, 2014**.

1. CLASS MEMBER INFORMATION.

_____
Name of Class Member as shown on PPO provider agreement

_____
Contact Person (if Class Member is not an individual)

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number Email Address

_____
Tax ID Number

2. CLAIM INFORMATION.

Please read the statements below and check the boxes to confirm that the statements apply to you. **If you cannot check all boxes, do not submit this Claim Form because you are not eligible to submit a claim as a Self-Identified Class Member.**

☐ I am a health care provider who currently has or had a First Health PPO provider agreement that was in effect at some time between April 1, 1998, and June 30, 2007.

The effective date of my provider agreement is/was _____.
The termination date of my provider agreement is/was _____.

☐ My First Health PPO provider agreement has an Appendix A that has the term "maximum amount payable" in the language for reimbursement for services provided to occupationally ill or injured employees.

☐ As instructed, I have included copies of:

1. The first page of my PPO provider agreement showing that it is a First Health provider agreement;
2. The signature page or other appropriate pages of my PPO provider agreement showing that it was executed by me and First Health and was in effect at some time between April 1, 1998, and June 30, 2007; and
3. The Appendix A to my PPO provider agreement showing that it uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees.

3. SIGN AND DATE YOUR CLAIM FORM.

I declare, under penalty of perjury, that the information in this Claim Form is true and correct to the best of my knowledge.

Signature: _____

Name (print): _____

Date: _____

4. MAIL YOUR CLAIM FORM.

This Claim Form (and all supporting documentation) must be postmarked by **Month 00, 2014** and mailed to: Coventry First Health Settlement, P.O. Box 0000, City ST 00000.

Payments will be made after final approval of the Settlement by the Court and after any appeals are resolved. This process may take time. Please be patient.

COVENTRY FIRST HEALTH SETTLEMENT

INSTRUCTIONS FOR CLAIM FORM FOR INDIVIDUAL CLAIM PAYMENT

You have received Notice of the settlement in *Chehalem Physical Therapy, Inc. v. Coventry Health Care, Inc.,* Case No. 3:09-CV-320-HU, along with a Base Guaranteed Payment. You may be eligible to receive an Individual Claim Payment under this Settlement as an Actual Damages Class Member. More information about the lawsuit and claims process is in the Detailed Notice available at www.CoventrySettlement.com or by calling 1-800-000-0000.

If you believe you are eligible to receive an Individual Claim Payment, you must mail the enclosed Claim Form, along with all required documentation listed below, to the Claims Administrator postmarked on or before **Month 00, 2014**. Please read and follow these instructions carefully.

1. INSTRUCTIONS.

- ☐ Fill out the enclosed Claim Form completely and accurately. **If you cannot check all boxes in Section 2 of the Claim Form, you are not eligible to submit a claim as an Actual Damages Class Member.**
- ☐ Sign and date the Claim Form, declaring its accuracy under penalty of perjury.
- ☐ Make at least two copies of each of the documents listed below.
- ☐ Mail a copy of the completed and signed Claim Form, along with one copy of each document listed below, by First Class mail postmarked by **Month 00, 2014**, to:

Coventry First Health Settlement
P.O. Box 0000
City, ST 00000

- ☐ Do not send any original documents to the Claims Administrator. The Claims Administrator will not return any documents to you.
- ☐ Keep a copy of all documents for your own records.

2. DOCUMENTATION (TO BE ENCLOSED WITH THE CLAIM FORM).

- ☐ The first page of your PPO provider agreement showing that it is a First Health provider agreement;
- ☐ The signature page and any other appropriate pages of your PPO provider agreement showing that it was executed by you and First Health and was in effect at some time between April 1, 1998, and June 30, 2007;
- ☐ The Appendix A to your PPO provider agreement showing that it uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees;
- ☐ A copy of each Explanation of Review ("EOR") for each procedure or service submitted to First Health for reimbursement under your PPO provider agreement between March

25, 1999, and the present, where: 1) your billed charge was less than the applicable state or federal fee schedule for that service, and 2) First Health applied a discount to your billed charge; and

- ☐ A copy of the applicable state or federal fee schedule amount in effect on the date of service for each procedure or service described above, or a copy of the applicable state rule or regulation determining provider reimbursement, along with any accompanying values.

3. CLAIMS ADMINISTRATION PROCEDURE.

All claims will be reviewed. The Claims Administrator will determine whether you are an Actual Damages Class Member eligible for an Individual Claim Payment based only on the Claim Form and documents you submit. However, the Claims Administrator may verify all or part of your claim (including the fee schedule or any other values you submitted,) through an independent review of other sources of information.

You can only qualify for an Individual Claim Payment to the extent that your claim amount is greater than the amount you are entitled to receive from the Guaranteed Fund, as described in the Detailed Notice and in Paragraph 9b of the Settlement Agreement available at www.CoventrySettlement.com.

Using the first page of your provider agreement the Claims Administrator will verify that:

- ☐ The contracting party is First Health and the agreement identifies you as the provider submitting the claim.
- ☐ Both you and First Health executed the provider agreement, and that your agreement was in effect at some time between April 1, 1998, and June 30, 2007.
- ☐ The Appendix A to your provider agreement uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees.

The Claims Administrator will then calculate the amount of your Individual Claim Payment (if any) as follows:

1. Payment will be based only on bill lines for which your billed charge for the service was less than the applicable state or federal fee schedule amount for that service. Bill lines in bills that were not paid on a bill line basis (such as those that have a capped amount, multiple reductions, maximum number of services, etc.) are not eligible for additional payment.
2. The percentage of "maximum amount payable" specified in the workers' compensation reimbursement language in your Appendix A will be applied to the billed charge for each eligible bill line.
   → If the percentage applied to the billed charge does not equal the reimbursement amount on the EOR, the bill line is not eligible for additional payment because reimbursement would not have been

calculated based upon the contract percentage applied to the billed charge.

→ If the percentage applied to the billed charge does equal the reimbursement amount on the EOR, the remaining steps will determine if the bill line is eligible for additional payment.

EXAMPLES:

Example 1.

The billed charge = $42.00
80% of the billed charge = $33.60
The state fee schedule amount = $46.05
80% of the state fee schedule amount = $36.84
The reimbursement amount indicated on the EOR = $33.60
Additional amount payable - $36.84 - $33.60 = $3.24

Example 2.

The billed charge = $42.00
80% of the billed charge = $33.60
The state fee schedule amount = $46.05
80% of the state fee schedule amount = $36.84
The reimbursement amount indicated on the EOR = $36.84
Additional amount payable = $0

3. The percentage of "maximum amount payable" specified in the workers' compensation reimbursement language in your Appendix A will be applied to the state or federal fee schedule amount for the service on each remaining eligible bill line.
4. You will be eligible to receive the difference between (a) the lesser of the amount calculated in Step 3 and the billed charge; and (b) the reimbursement amount for the bill line indicated on the EOR.
5. Your Individual Claim Payment will be the total of the amounts calculated using this process for all eligible bill lines, minus the amount payable to you from the Guaranteed Fund, as explained in the Detailed Notice you received.

4. IMPORTANT INFORMATION.

Claim Forms that do not meet the requirements described in these instructions will be rejected. In addition, the Claims Administrator may reject your Claim Form for any of the following reasons:

- ☐ Failure to provide adequate documentation of your claim;
- ☐ Failure to fully complete and/or sign the Claim Form;
- ☐ Any information on the Claim Form or supporting documentation is false or inaccurate;
- ☐ Your Claim Form duplicates another Claim Form;

- ☐ You are not a member of the Settlement Class; or
- ☐ The amount of your Individual Claim Payment is less than the amount you are entitled to receive from the Guaranteed Fund, as described in the Detailed Notice and in Paragraph 9b of the Settlement Agreement.

The Claims Administrator will notify you if your claim is invalid, challenged, or rejected. You must keep the Claims Administrator informed of your current mailing or email address. If you do not, you may not receive payment. If you have any questions about the claims process, please contact Class Counsel or the Claims Administrator. Please do not contact the Court or Coventry's counsel with questions about the claims process.

Payments will be made after final approval of the Settlement by the Court and after any appeals are resolved. This process may take time. Please be patient.

Must Be Postmarked No Later Than Date

Coventry First Health Settlement Administrator
P.O. Box 0000
City, ST 00000

COVENTRY FIRST HEALTH SETTLEMENT CLAIM FORM

INDIVIDUAL CLAIM PAYMENT FOR ACTUAL DAMAGES CLASS MEMBERS

If you want to receive an Individual Claim Payment under this Settlement, you must provide the information requested below with the required documentation. Please print clearly in blue or black ink.

More information is available at the official Settlement website, www.CoventrySettlement.com, or by calling 1-800-000-0000. This Claim Form must be mailed and postmarked on or before **Month 00, 2014.**

2. CLASS MEMBER INFORMATION.

_____
Name of Class Member as shown on PPO provider agreement

_____
Contact Person (if Class Member is not an individual)

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number Email Address

_____
Tax ID Number

2. CLAIM INFORMATION.

Please read the statements below and check the boxes to confirm that the statements apply to you. **If you cannot check all boxes, do not submit this Claim Form because you are not eligible to submit a claim as an Actual Damages Class Member.**

☐ I am a health care provider and who currently has or had a First Health PPO provider agreement that was in effect at some time between April 1, 1998, and June 30, 2007.

The effective date of my provider agreement is/was _____.
The termination date of my provider agreement is/was _____.

☐ My First Health PPO provider agreement has an Appendix A that has the term "maximum amount payable" in the language for reimbursement for services provided to occupationally ill or injured employees.

☐ I submitted at least one bill to First Health for reimbursement under my PPO provider agreement for services provided to a workers' compensation patient between March 25, 1999, and September 3, 2014.

☐ For at least one of these bills, my billed charge was less than the applicable state or federal fee schedule for that service, and First Health applied a discount to my billed charge.

☐ As instructed, I have submitted copies of:

1. The first page of my PPO provider agreement showing that it is a First Health provider agreement;
2. The signature page or other appropriate pages of my PPO provider agreement showing that it was executed by me and First Health and was in effect at some time between April 1, 1998, and June 30, 2007;
3. The Appendix A to my PPO provider agreement showing that it uses the term "maximum amount payable" in the language relating to reimbursement for services provided to occupationally ill or injured employees;
4. A copy of each Explanation of Review ("EOR") for each eligible procedure or service submitted to First Health for reimbursement under my PPO provider agreement between March 25, 1999, and September 3, 2014, where: a) the billed charge was less than the applicable state or federal fee schedule for that service, and b) First Health applied a discount to the billed charge; and
5. A copy of the applicable state or federal fee schedule amount in effect on the date of service for each eligible procedure or service or a copy of the applicable state rule or regulation determining provider reimbursement, along with any accompanying values.

3. SIGN AND DATE YOUR CLAIM FORM.

I declare, under penalty of perjury, that the information in this Claim Form, and all supporting documentation submitted with this Claim Form, is true and correct to the best of my knowledge.

Signature: _____

Name (print): _____

Date: _____

4. MAIL YOUR CLAIM FORM.

This Claim Form (and all supporting documentation) must be postmarked by **Month 00, 2014**, and mailed to: Coventry First Health Settlement, P.O. Box 0000, City ST 00000.

Payments will be made after final approval of the Settlement by the Court and after any appeals are resolved. This process may take time. Please be patient.